Executive Summary

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The Medicare Payment Advisory Commission (MedPAC) presents in this report its recommendations on Medicare payment policy issues for fiscal year 2000. The Commission's recommendations fulfill MedPAC's legislative mandate to consider, develop, review, and advise the Congress on improvements to the program. In arriving at these recommendations, we have taken into account Medicare's role in the broader health care financing and delivery system and the changes occurring in both the program and the environment in which it functions. Our recommendations are intended to ensure that the Medicare program pays appropriately for covered services and maintains access to quality health care for its beneficiaries.

The Commission's recommendations address the following areas of concern:

- the Medicare+Choice program,
- the acute care hospital inpatient prospective payment system,
- payments for facilities exempted from the acute care prospective payment system,
- development of new payment systems for post-acute care providers,
- modification of payment for services provided in ambulatory care facilities,
- continued reform of the Medicare fee schedule for physicians, and
- the composite rate for outpatient dialysis services.

They represent the collective judgment of MedPAC's 15 commissioners, based on qualitative and quantitative analyses of the relevant issues, discussion of the findings and implications, and deliberations as to the appropriate policy responses.

Payment policy framework

This report begins by describing a framework for considering Medicare payment policy issues. Because the predominant focus of Medicare payment policy over the past 15 years, and a primary emphasis of the Balanced Budget Act of 1997 (BBA), has been on developing prospective payment systems (PPS) for a growing list of provider categories, the chapter focuses on these systems. Key design decisions and the factors that may influence choices among alternative options are illustrated by examining existing fee-for-service systems, such as those used by Medicare for hospital inpatient care and physicians' services. The same approach can be applied to developing payment rates for Medicare+Choice organizations, so that system also is considered in this context.

Medicare's payment policies should ensure that beneficiaries have access to medically necessary care of reasonable quality in the most appropriate setting. At the same time, the program should not spend more than is required to achieve that goal. Payment rates must then be consistent with the costs of efficiently providing the necessary level of care, offering fair payment to providers while not interfering with clinical decisions as to the amount of care or the setting in which it is provided. Accomplishing these objectives involves numerous decisions that determine the level of payment, how it is distributed, and how the system is maintained over time.

Although the decisions themselves may vary with the circumstances related to each type of provider or service, a consistent framework for making those decisions can and should be used.

The Medicare+Choice program

One of the major initiatives of the BBA was to make a wider variety of private health care coverage options available to Medicare beneficiaries by expanding the previous risk contracting program into Medicare+Choice. However, changes in the way the payment rates are determined, the establishment of new regulations in implementing the program, and concurrent trends in the health insurance environment have resulted in the availability of few new options and, in fact, a decline in the number of Medicare risk plans.

It is too soon to tell whether the recent departures from Medicare stem from systematic problems with the level or distribution of payment, but we plan to monitor this situation further in the next year. In the meantime, however, the Health Care Financing Administration (HCFA) should continue to work with the relevant parties to identify specific changes to regulations or other policies that would reduce the burden of compliance without compromising the objectives of the program. Two such changes include moving the deadline by which Medicare+Choice organizations must file their premiums and benefit packages and allowing them to vary their benefit packages by county within their service areas.

The Commission supports the Secretary of Health and Human Services' plan to phase in, beginning in 2000, an interim risk adjustment mechanism for Medicare+Choice payments, which is based solely on data from hospital admissions. As quickly as feasible, however, the risk adjustment mechanism should incorporate diagnosis data from all sites of care. These changes should improve the correspondence between payments to Medicare+Choice organizations and the costliness of their enrollees.

The acute care hospital inpatient prospective payment system

Although the annual updates to the operating payment rate under the Medicare hospital inpatient PPS already are set in law, MedPAC each year provides guidance to the Congress on the appropriate update for the upcoming fiscal year. Based on our ongoing analyses of the factors that determine year-to-year changes in hospital costs, we believe that the operating update for fiscal year 2000 that was enacted in the BBA—1.8 percentage points less than the increase in HCFA's hospital operating market basket index—will provide reasonable payment rates. If the current market basket forecast holds, the update would be 0.7 percent.

The PPS capital payment rate update is set by the Secretary of Health and Human Services each year. The Commission's recommendation on the PPS capital update for fiscal year 2000 is a range between 3.0 percentage points and 0.1 percentage point below the increase in HCFA's hospital capital market basket index, which would be between -1.1 percent and 1.8 percent if the current forecast holds.

These recommendations are made in the context of evidence that the hospital industry has thus far successfully adapted to a more competitive market by changing

its practice patterns and reducing its costs, but also out of concern that many of the major effects of the BBA are not yet fully evident. Therefore, reducing payment rates below the level prescribed in the BBA would not be prudent, at least for this year.

MedPAC also is recommending a revision in the methodology for providing extra payments to hospitals that care for a disproportionate share of poor patients. These disproportionate share payments are made through a complex formula that determines the percentage add-on to each hospital's PPS payments based on its location, size, certain other characteristics, and a measure of care to the poor. The measure of care to the poor, however, excludes uncompensated care and local indigent care programs, which represent a large share of the burden faced by many hospitals that treat poor patients. Moreover, under the current formula, rural and small urban hospitals that treat a disproportionate share of poor patients receive a much smaller adjustment (if any) than large urban hospitals with the same share. Our recommendations are intended to eliminate these flaws.

Payments for facilities exempted from the acute care prospective payment system

Certain types of hospitals and distinct part units of hospitals are exempt from the acute care PPS. PPS-exempt facilities are a diverse group that share a common Medicare payment method established by the Tax Equity and Fiscal Responsibility Act of 1982; they include rehabilitation, long-term, psychiatric, children's, and cancer hospitals, and rehabilitation and psychiatric units in acute care hospitals. Each of these facilities is paid an amount based on its own costs in the payment year relative to a per-discharge target that depends on its costs in a base year, updated to the payment year.

MedPAC's analysis of the factors that determine year-to-year cost increases for PPS-exempt facilities indicates that the update factor applied to the per-discharge targets in fiscal year 2000 should be increased by 0.4 percentage point more than in the formula prescribed in the BBA. The BBA also established a category-specific cap on the per-discharge targets for rehabilitation and psychiatric facilities and long-term hospitals but did not provide that these nationwide caps be adjusted for differences in input prices across areas. We recommend the correction of that technical oversight.

The BBA also required that Medicare implement a new payment system for rehabilitation facilities, and that the Secretary of Health and Human Services develop a proposal for long-term hospitals; it did not mention psychiatric facilities, however. MedPAC encourages additional research in case-mix classification for psychiatric patients, with an eye toward developing a PPS for them in the future.

New payment systems for post-acute care providers

The BBA mandated substantial changes in Medicare payment policy for providers of post-acute care. In addition to the above-mentioned work on new payment systems for rehabilitation facilities and long-term hospitals, a PPS for skilled nursing facilities (SNF) was implemented in July 1998, and an interim payment system for home health agencies was put in place in October 1997 until a PPS can be developed. To guide the development of consistent payment policies across post-acute care settings, MedPAC recommends that common data elements be collected to help identify and quantify the overlap of patients treated and services provided. Further, it is important to put in

place quality monitoring systems in each setting to ensure that adequate care is provided in the appropriate site. We also support research and demonstrations to assess the potential of alternative patient classification systems for use across settings to make payments for like services more comparable.

The Commission has several recommendations to improve the PPS for SNFs. More work is needed in refining the patient classification system used in the PPS for SNFs, particularly in its ability to predict the costs of nontherapy ancillary services. Alternative ways of grouping rehabilitation services provided in SNFs also may be called for to reduce reliance on measurements of rehabilitation time. A methodology for updating the relative weights that determine how much facilities are paid for each type of patient is crucial as the system and the types of services that are provided change over time. In general, as better data become available with the new system, distortions in the base payment rates due to imperfections in the initial data and measures used should be detected and corrected. To avoid future problems, facilities must be accountable for accurately assessing patients' needs and reporting the data used to determine payment for each case. Finally, the distribution of payments would be more appropriate if they were adjusted using a wage index based on data from SNFs, rather than hospitals.

As payment systems for rehabilitation facilities and long-term hospitals are developed, a number of crucial decisions must be made. Among them is the unit of payment. MedPAC recommends that a per-discharge mechanism be adopted for rehabilitation services. A system currently exists that could serve as a basis for such an approach, perhaps with some modifications. We also recommend that, in choosing a patient classification methodology for a long-term hospital PPS, HCFA consider not only per diem but also existing and potential per-discharge approaches.

The interim payment system for home health agencies that was created in the BBA was the subject of a great deal of controversy in the year following its enactment. This controversy stems, in part, from the use of payment policy as a vehicle for curbing the rapidly rising cost of a vaguely defined benefit. Although the debate appears to have at least temporarily subsided with recent changes in the system, MedPAC believes that more fundamental changes are necessary even as a new payment system is being developed. We urge the Congress, in consultation with the Department of Health and Human Services, to enact clearer eligibility and coverage guidelines for Medicare home health services. To understand better the content of home health visits, agencies' bills should describe the specific services provided. Moreover, we recommend that an independent assessment of need be conducted for Medicare beneficiaries who receive extensive home health care to ensure that care is appropriately coordinated and suits the needs of the patient within the proscription of the benefit. Finally, modest beneficiary cost-sharing should be introduced for home health services; copayments should be subject to an annual limit, and low-income beneficiaries and those eligible for Medicaid should be exempt from this requirement.

Payment for services provided in ambulatory care facilities

Spending for facility-based ambulatory services has grown substantially since the early 1980s, partly because the combination of financial incentives and technological advances encouraged the shifting of services that once were provided exclusively in the inpatient setting to hospital outpatient departments (OPD) and ambulatory surgical centers (ASC) as well as physicians' offices. Medicare pays for many of these services differently according to where they are provided. MedPAC offers several recommendations on making payments more equitable across settings and services.

The Commission makes several recommendations that apply to payment for ambulatory care in general. Consistent with the way that Medicare pays for physicians' services, the unit of payment should be the individual service (the primary service and the ancillary supplies and services integral to it), rather than a larger bundle of services. Accordingly, the relative costs of the individual service should determine payment, rather than groups of services taken together. In setting payment rates, the pattern of services and costs across ambulatory settings should be taken into account. Moreover, a single update mechanism, linking updates to spending growth across all ambulatory care settings, should be applied to the payment rates for each type of provider.

The Secretary of Health and Human Services has proposed a new payment system for hospital outpatient services (as required in the BBA) and major modifications in the payment system for ambulatory surgical centers. MedPAC recommends that these changes be closely monitored to ensure that beneficiary access to appropriate care is not compromised in the face of substantial reductions in payments to hospital OPDs. In particular, payments should reflect the higher costs of treating certain types of patients; in the absence of adequate patient-level indicators, facility-level adjustments may be required for the time being. We also are concerned that the loosening of guidelines for determining whether a procedure is eligible for coverage in an ASC may lead to inappropriate changes in the pattern of service provision across ambulatory settings.

In addition, although the BBA provided for a gradual reduction in the amount of beneficiary coinsurance for hospital OPD services, it would be years before that amount were reduced to a level comparable with that for similar Medicare-covered services. MedPAC recommends that the reduction in this amount be accelerated, with increased program spending used as necessary to avoid corresponding decreases in hospital payments.

The Medicare fee schedule for physicians

The BBA mandated a number of changes in the Medicare fee schedule for physicians. Although the resource-based work component of the fee schedule has been in place for several years, HCFA recently began a phase-in of a new resource-based methodology for the practice expense component (which it intends to refine as it is used) and is developing revisions to the professional liability component. In addition, the BBA replaced the mechanism by which the payment rates for physicians' services are updated.

For some services, it is appropriate to pay a lower practice expense amount when physicians perform the service in facility-based settings outside the office. MedPAC recommends using a service-by-service approach to decide which services are subject to this site of service differential, rather than applying the same decision to entire groups of services. Services generally recognized as inappropriate to perform in a physician's office should be paid at the lower facility practice expense level. Participants with a wide variety of relevant expertise should be included in developing refinements to the practice expense component of payment.

The professional liability component of the fee schedule should reflect the risk involved in providing each service and, therefore, conform more closely to the notion of resource-based payment.

MedPAC also recommends several modifications to the sustainable growth rate (SGR) system enacted in the BBA for updating physician payment rates. These include revising the SGR to include measures of changes in the composition of Medicare fee-for-service enrollment to reflect cost increases due to desirable improvements in medical capabilities and technology and to correct for inaccuracies in the forecasts used in estimating the SGR each year. We also call for a reduction in time lags between the periods on which the various components of the SGR are based and the earlier availability of estimated updates for each upcoming year.

The composite rate for outpatient dialysis services

MedPAC is required to recommend an appropriate update to the composite rate for outpatient dialysis services each year. The Commission's analysis indicates that, although the dialysis industry has been profitable and firms continue to enter the market despite the lack of a significant update in the composite rate since it was established in 1983, costs have been approaching payments in recent years. We are concerned that further increases in dialysis costs relative to the payment rate may cause quality to deteriorate and, therefore, recommend that the rate be increased by between 2.4 percent and 2.9 percent. We also urge that the increasing emphasis on the quality of care received by dialysis patients continue, and efforts to collect and evaluate information on patient care and treatment patterns proceed. ■